Fall Prevention

In the Emergency Department

Elizabeth Folger, RN

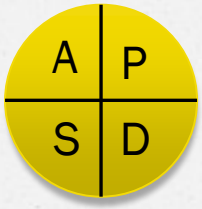
BSN

CNL

PCCN

MS in IL

Improvement Ramp



Quality by Design

A clinical Microsystems approach

E.C. Nelson, P.B. Batalden, & M.M. Godfrey

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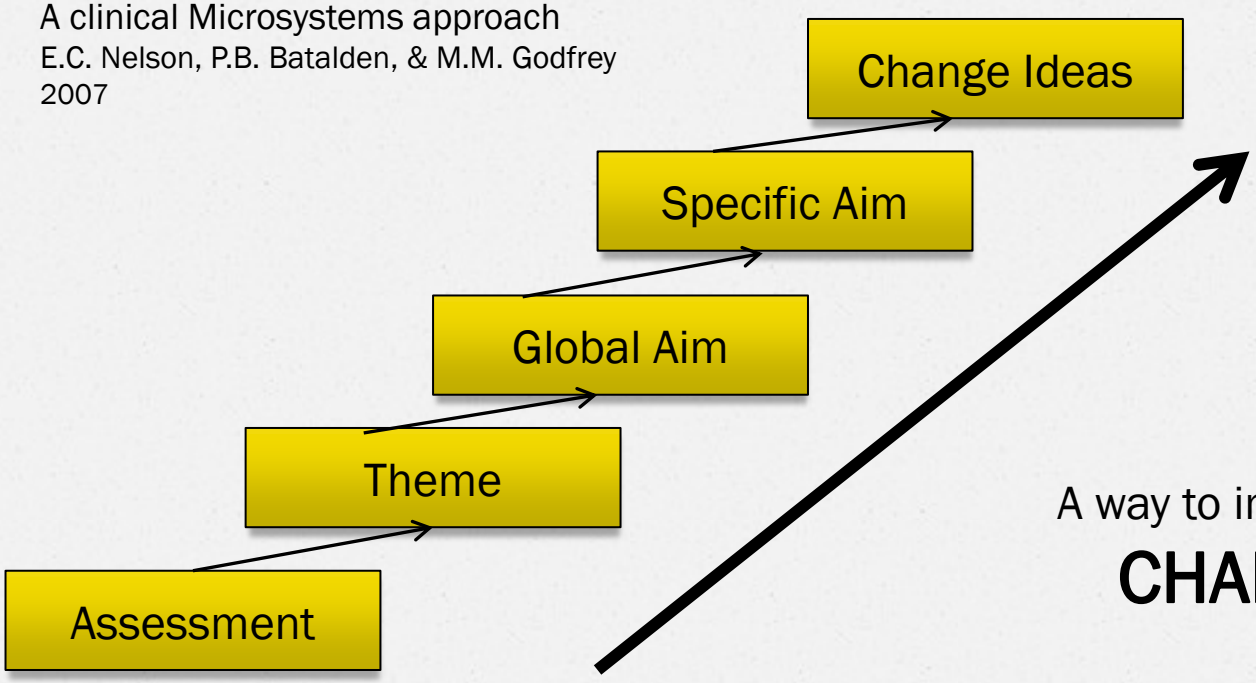


A way to implement

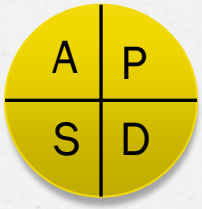
CHANGE

Assessment

Microsystem

- IMMC ED
- 5 P's
  - Purpose
  - Patients
  - Professionals
  - Processes
  - Patterns

Improvement Ramp



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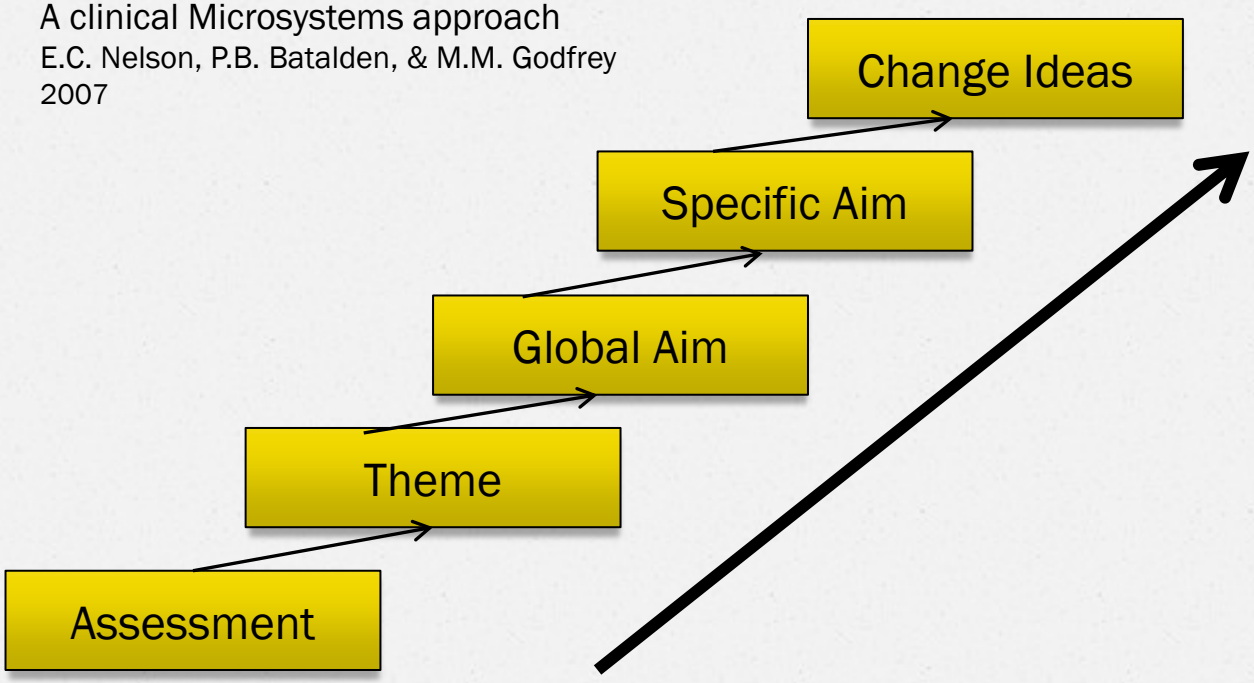
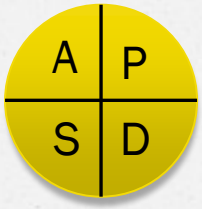


Theme

- Falls 4th chief complaint in 2014
- No process for when to complete fall assessment tool
- At least 8 reported falls in 2014

Improvement Ramp



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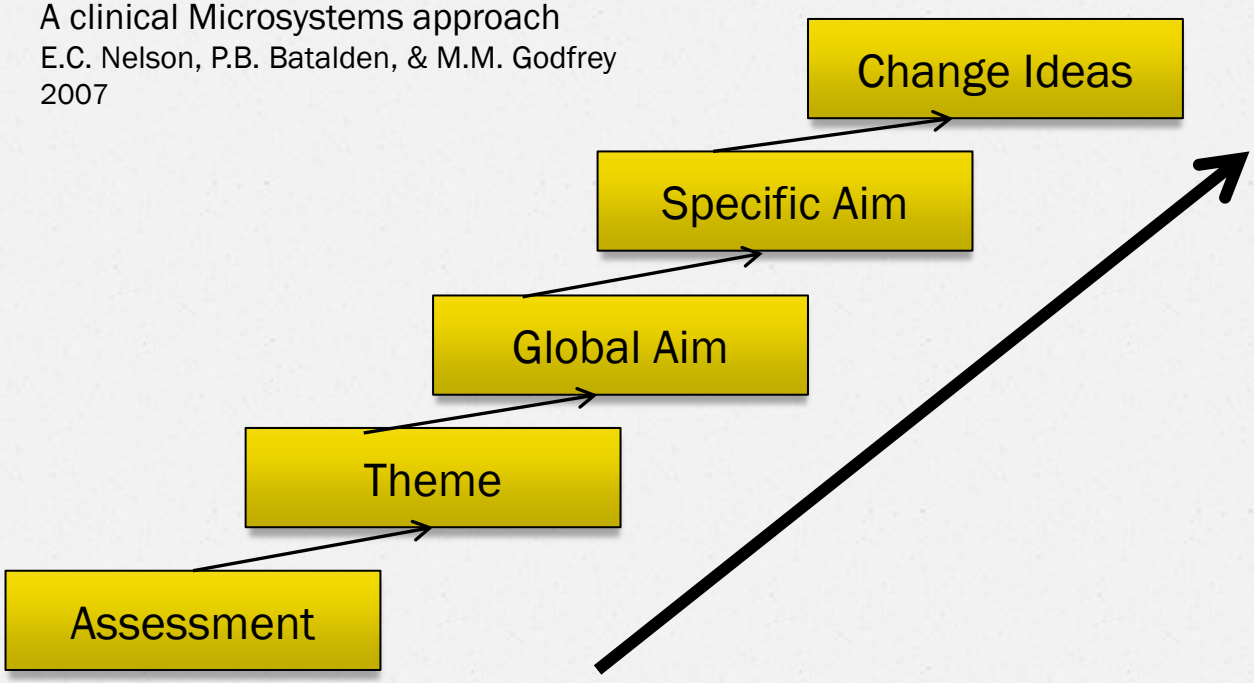
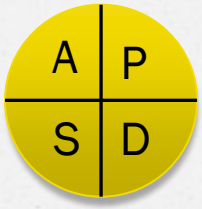


Global Aim

- I aim to improve patient safety in the emergency department (ED). The process begins with identifying why patients are falling, and finding the best assessment tool that captures patients at risk of falling. The process ends with 100% participation in the utilization of ED specific fall screen. By working on the process, I expect a decrease in patient falls, an increase in patients' sense of safety, and decrease in fall readmissions. It is important to work on this now because I have identified the need to improve prevention and preparation to care for patients at risk for falls.

Improvement Ramp



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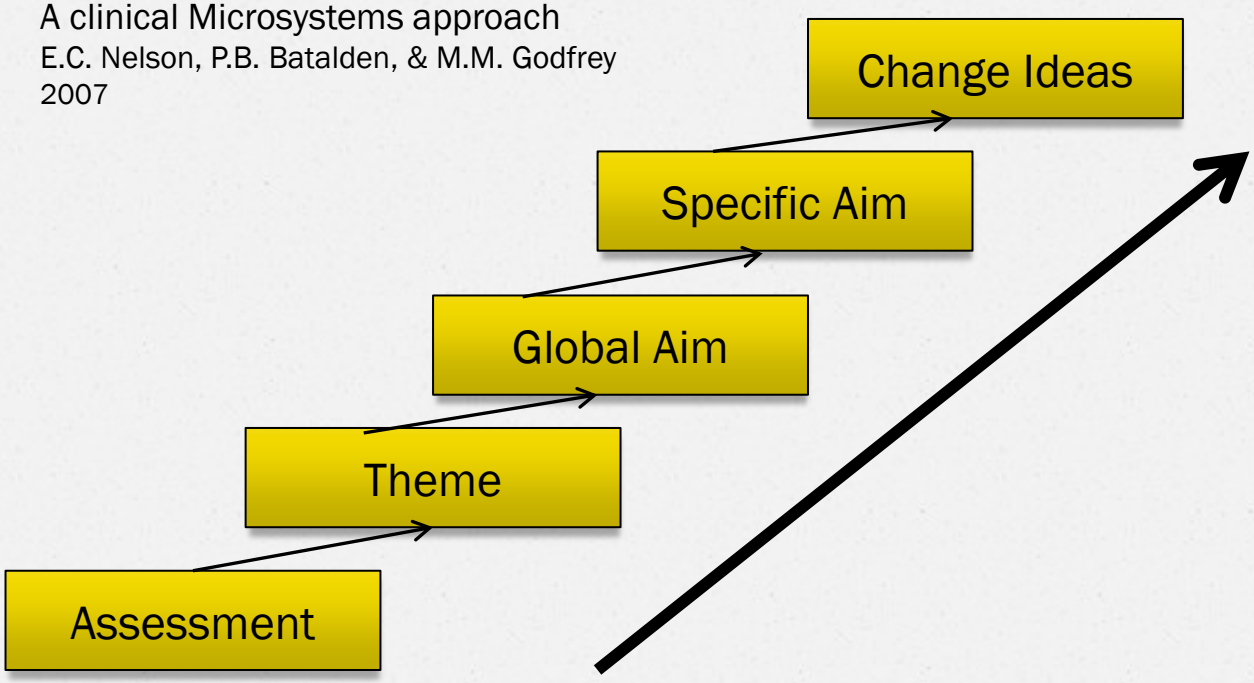
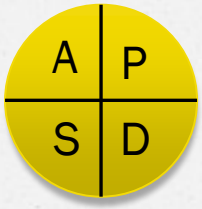


Specific Aim

- I aim to reduce the amount of falls in the ED by 75%. An ED specific screen will be assessed on 100% of patients. Appropriate preventative measures will be initiated on all patients at risk for falls.

Improvement Ramp



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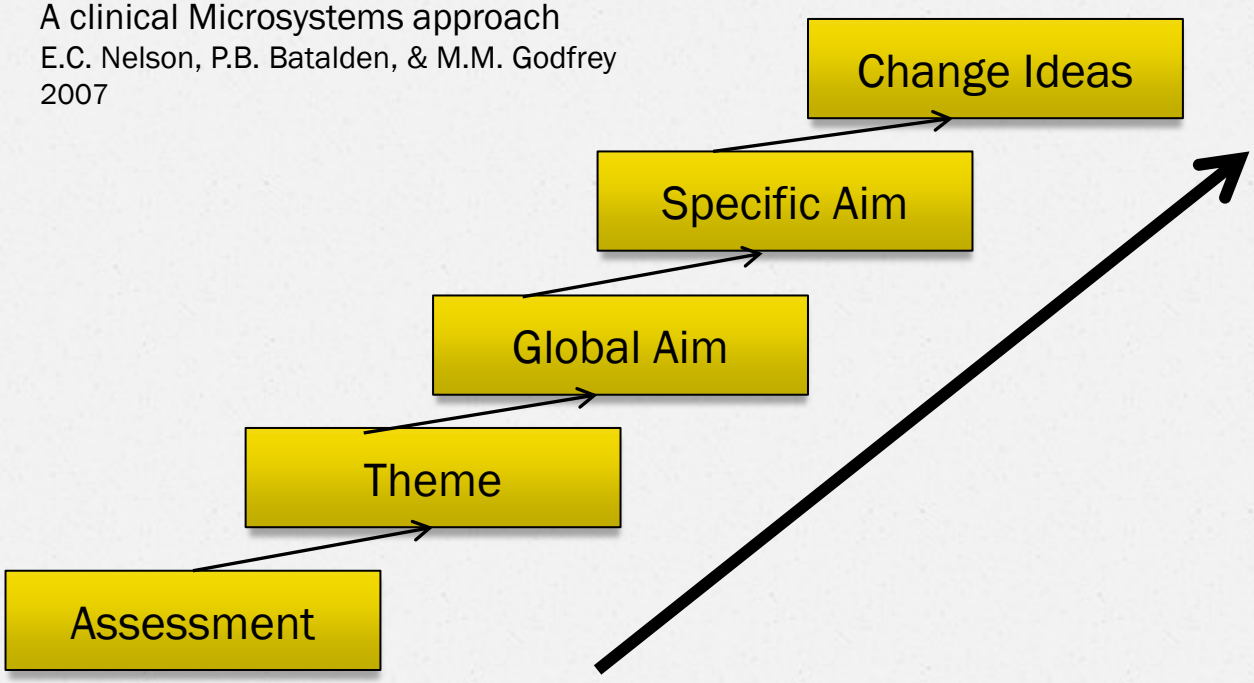
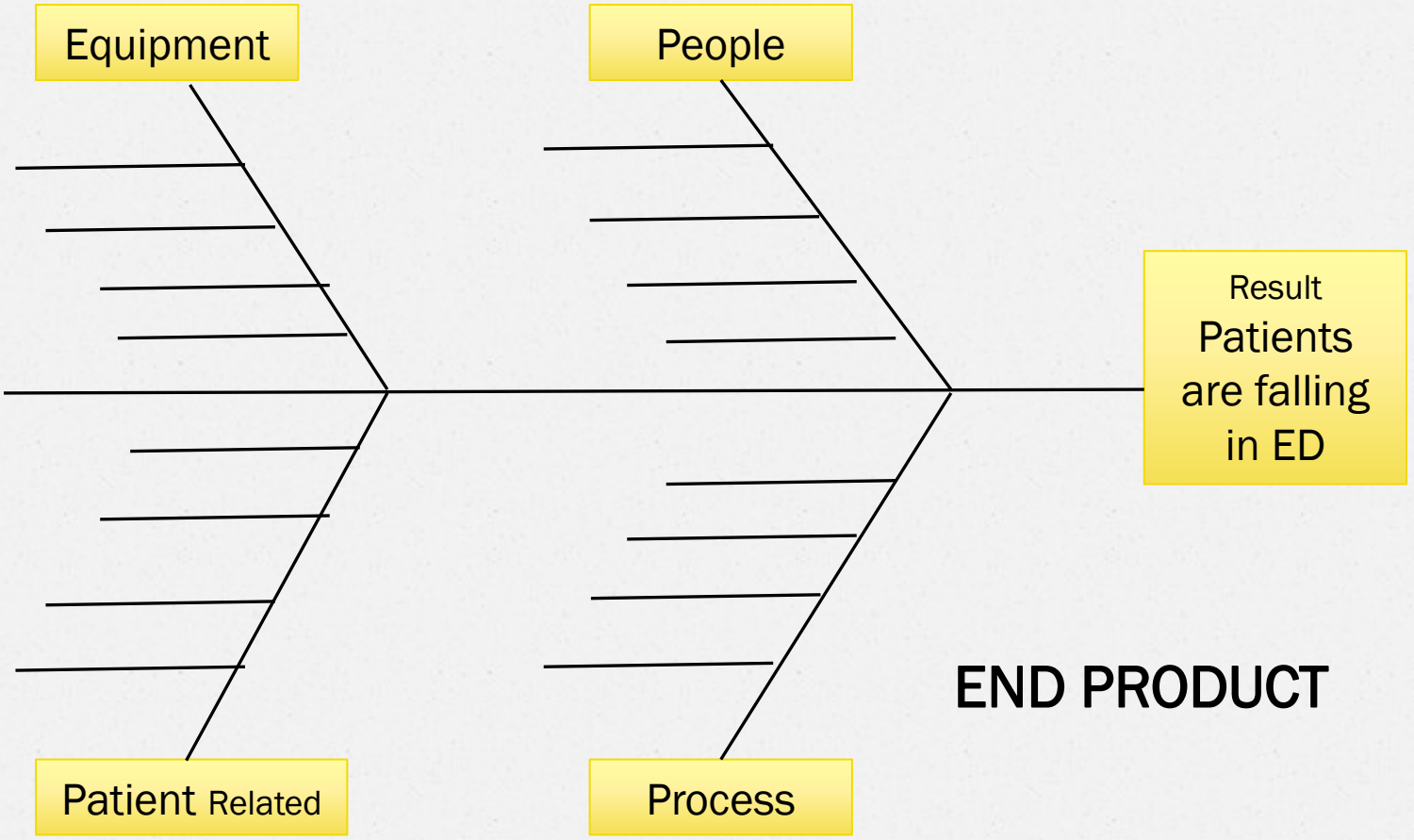


Change Ideas



Literature Review

Statistics

- 1 in 3 adults greater than 65 fall each yr.
  - In 2009, > 1.59 million went an ED
- 30% with hip fractures die within year
- In 2006, fall-related events for 65 y or older cost 19 billion dollars

Iowa

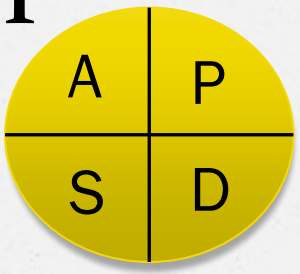
- Death rate has risen 20% over the past 5 y
- Hospitalization rate 3.54/1,000 (IA)
  - >65 y = 17.38/1,000
- 1.49 billion dollars spent in Iowa between 2009 and 2013
- Average cost per hospitalization is $27,569

Literature Review

Themes

- ED specific tool
- Implement interventions
- Prevention Program

Improvement Ramp



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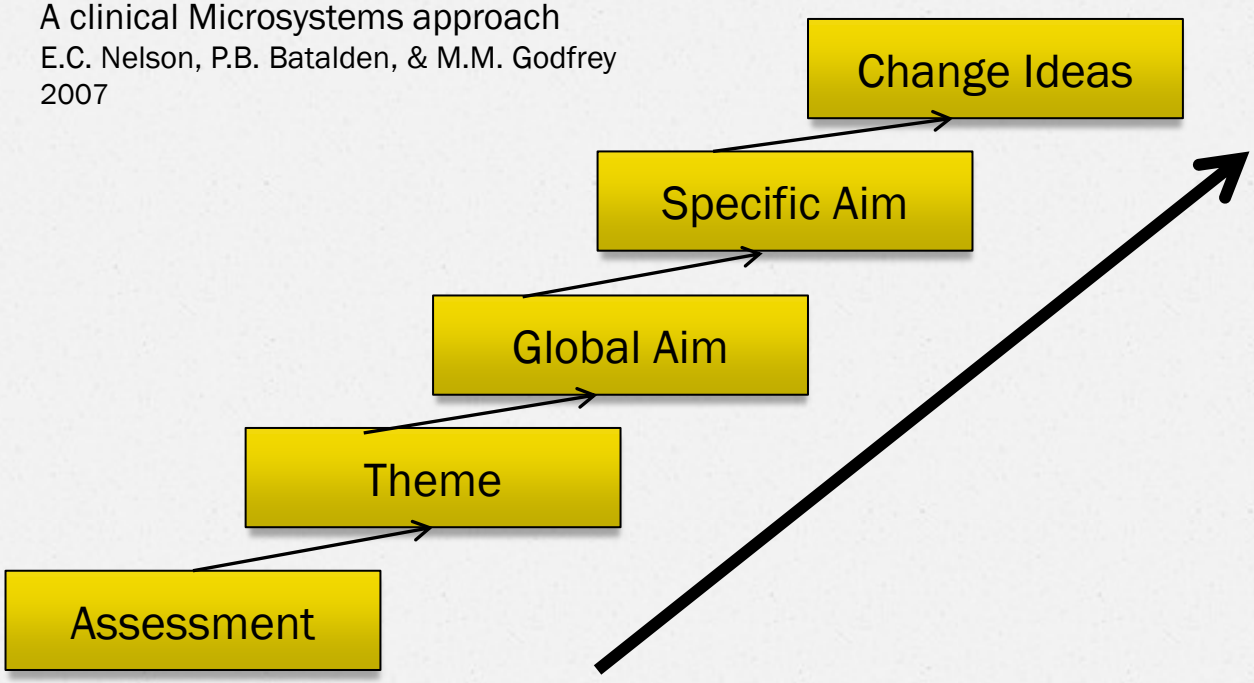
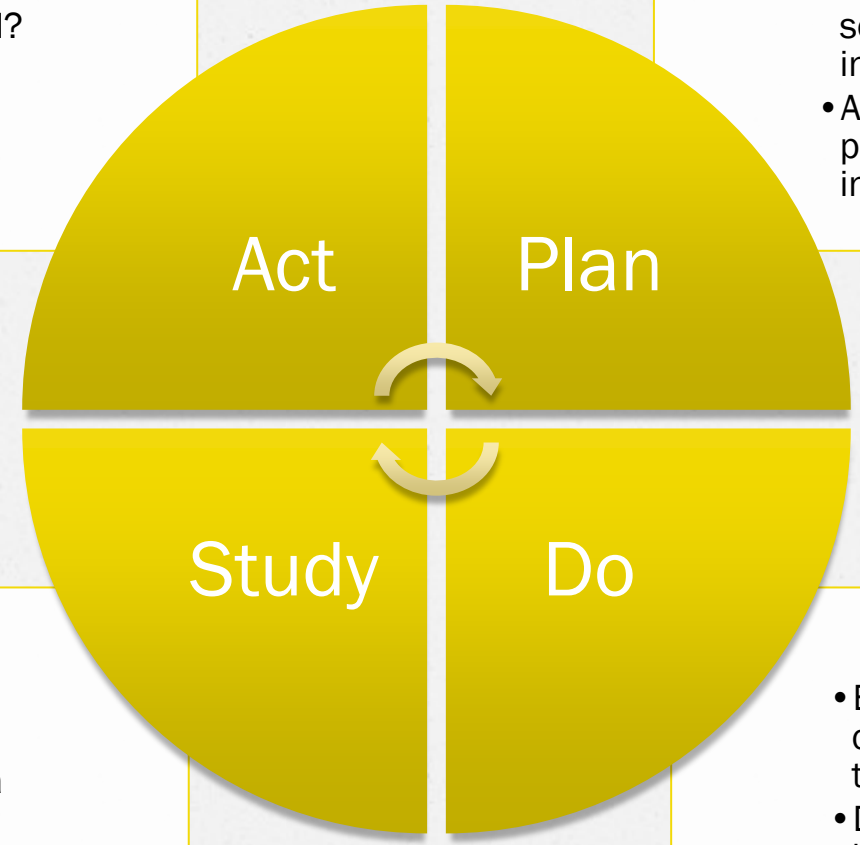


Pilot

- Does the screen need modified?
  - Next Step?

- RN complete screen at time of initial triage
- Appropriate fall precautions initiated



- Screens completed?
- How does data compare to predictions?

- Both screens completed at time of Triage
- Data collection begins

PLAN

Morse

History of Falling
- No
- Yes (25 points)

Secondary Diagnosis
- No
- Yes (15 points)

Ambulatory Aid
- No
- Crutches/cane/walker (15 points)
- Furniture (30 points)

IV
- No
- Yes (20 points)

Gait
- No
- Weak (10 points)
- Impaired (20 points)

Mental Status
- No
- Yes (15 points)

Fall Risk Score ☐

Low Risk = < 24 points

Moderate risk = 25-44 points

High Risk = > 45 points

Vs.

ED Tool

History

History of Falling in Last 3 Months, Including Since Admission
- No
- Yes- single mechanical fall (1 point)
- Yes- physiological fall/syncope (2 points)
- Yes- fall prone/multiple falls (3 points)

Observation

Confusion or Disorientation
- No
- Yes (5 points)

Intoxicated or Sedated
- No
- Yes (3 points)

Impaired Gait
- No
- Yes (1 point)

Mobility Assist Device Used
- No
- Yes (1 point)

Altered Elimination
- No
- Yes (1 point)

Fall Risk Score ☐

Low Risk = 1-2 points

Recommend initiating fall precautions.

Moderate risk = 3-4 points

Initiate fall precautions. Preform TUG prior to discharge.

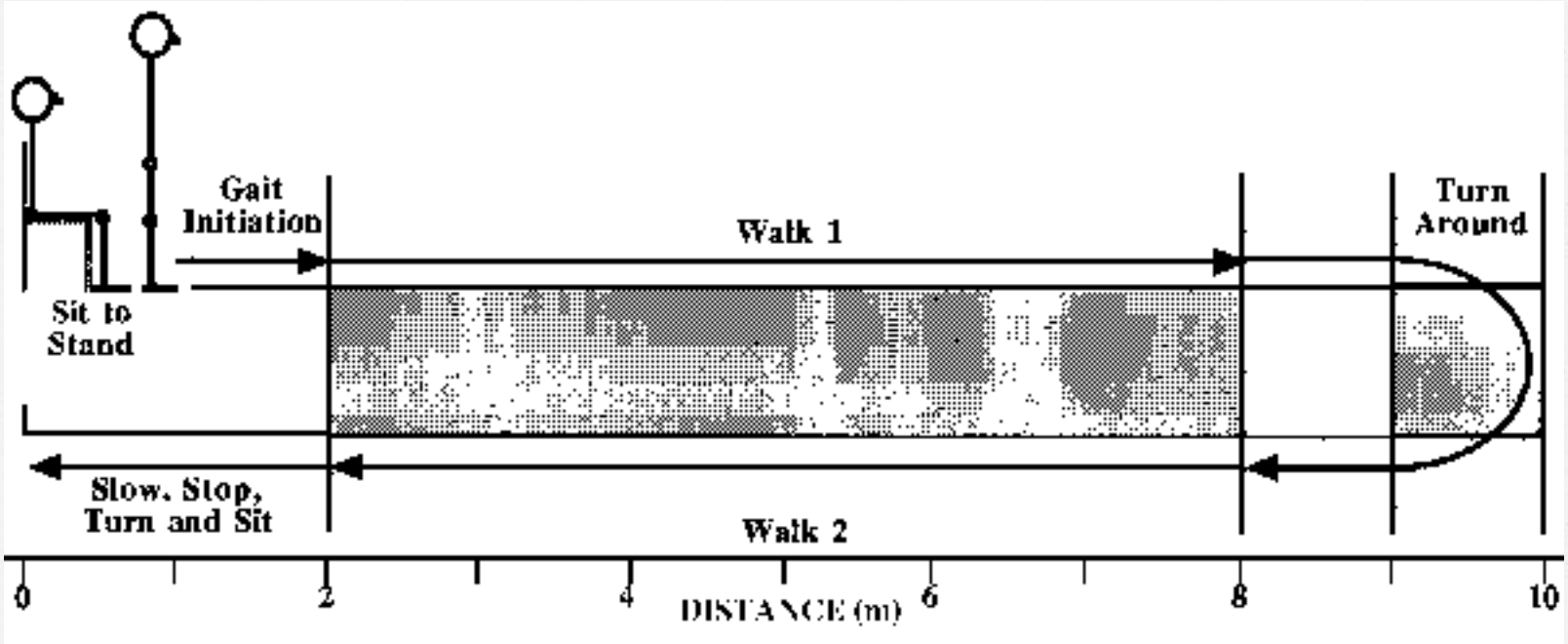
High Risk = 5 points or more

- Fall precautions initiated
  - Wrist band
  - Nonskid socks
  - Personal alarm

- TUG test preformed: Result ☐
  PT referral?
  - No, Why not _____
  - Yes

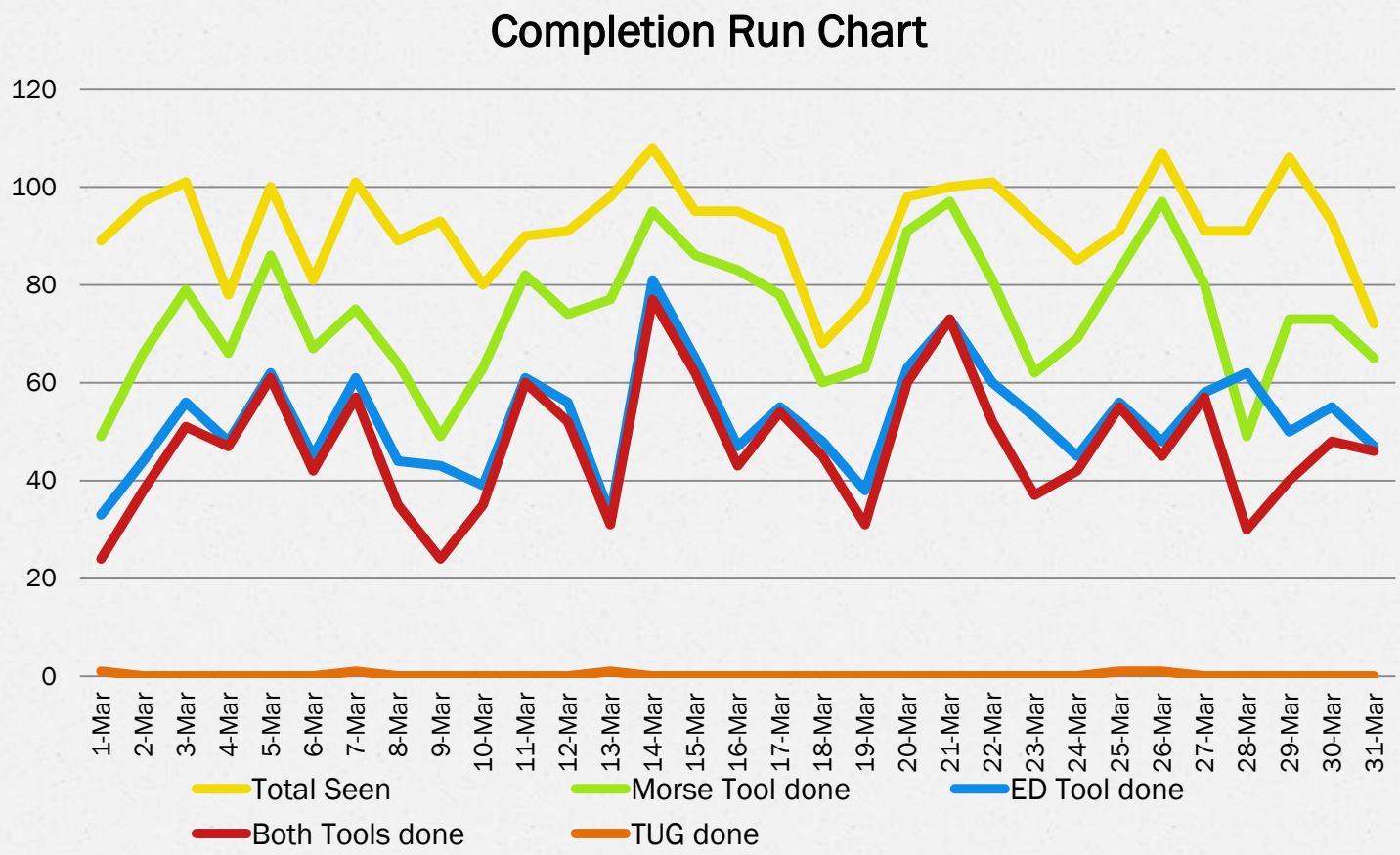
PLAN

TUG test



DO

Results


Completion Run Chart
120
100
80
60
40
20
0
1-Mar
2-Mar
3-Mar
4-Mar
5-Mar
6-Mar
7-Mar
8-Mar
9-Mar
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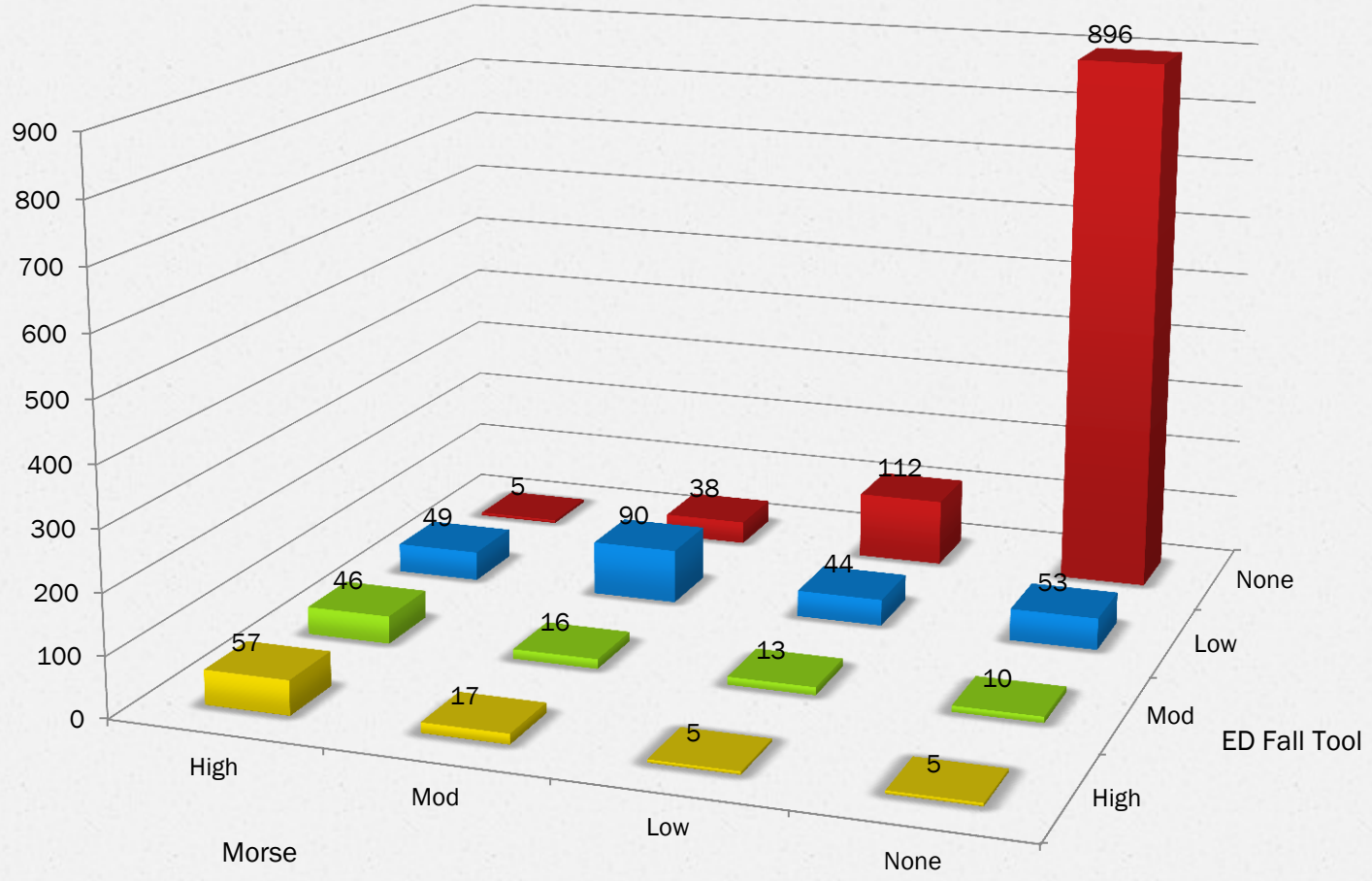
22-Mar
23-Mar
24-Mar
25-Mar
26-Mar
27-Mar
28-Mar
29-Mar
30-Mar
31-Mar
Total Seen
Morse Tool done
ED Tool done
Both Tools done
TUG done

STUDY

Results



Study

- Morse vs. ED Specific Tool
- Nurse Survey

ACT

Recommendation

- ED Fall Risk Assessment Tool
- Policy
- Education

Result

- Key stakeholders at UnityPoint DSM accepted proposal
- ED specific screen awaiting system wide approval

Questions